



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-418-5515

Typhoid Fever

County _____

LHJ Use ID _____

☐ Reported to DOH

Date ____/____/____

LHJ Classification

☐ Confirmed

☐ Probable

By: ☐ Lab ☐ Clinical

☐ Other: _____

Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____

Date Received ____/____/____

DOH Classification

☐ Confirmed

☐ Probable

☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Phone: _____

Occupation/grade _____

Employer/worksites _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived

Diagnosis date: ____/____/____

Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Diarrhea** Maximum # of stools in 24 hours: _____

☐ ☐ ☐ ☐ **Constipation**

☐ ☐ ☐ ☐ Abdominal cramps or pain

☐ ☐ ☐ ☐ **Loss of appetite (anorexia)**

☐ ☐ ☐ ☐ **Fever** Highest measured temp (°F): _____

☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Night sweats

☐ ☐ ☐ ☐ Headache

☐ ☐ ☐ ☐ Malaise

☐ ☐ ☐ ☐ Cough Onset date: _____

☐ ☐ ☐ ☐ **Nonproductive cough**

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ Typhoid vaccine in past 5 years

Date of last vaccination (mm/yyyy): ____/____/____

Typhoid vaccine type: _____

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Previously known typhoid carrier

☐ ☐ ☐ ☐ Immunosuppressive therapy or disease

☐ ☐ ☐ ☐ Underlying illness Specify: _____

Laboratory

P = Positive O = Other, unknown

N = Negative NT = Not Tested

I = Indeterminate

Collection date ____/____/____

P N I O NT

☐ ☐ ☐ ☐ ☐ **S. typhi culture (clinical specimen)**

NOTES

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ **Rash - rose spots**

☐ ☐ ☐ ☐ Splenomegaly

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:

Exposure period

-30

-3

onset

Contagious period

weeks

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
- ☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**
- ☐ ☐ ☐ ☐ Contact with lab confirmed case
☐ Casual ☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ Contact with known typhoid carrier
☐ Casual ☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ Contact with diapered or incontinent child or adult
- ☐ ☐ ☐ ☐ Refrigerated, prepared food (e.g. dips, salsas, salads, sandwiches)
- ☐ ☐ ☐ ☐ Unpasteurized milk (cow)

Y N DK NA

- ☐ ☐ ☐ ☐ Known contaminated food product
- ☐ ☐ ☐ ☐ Group meal (e.g. potluck, reception)
- ☐ ☐ ☐ ☐ Food from restaurants
Restaurant name/Location: _____
- ☐ ☐ ☐ ☐ Source of drinking water known
☐ Individual well ☐ Shared well
☐ Public water system ☐ Bottled water
☐ Other: _____
- ☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)
- ☐ ☐ ☐ ☐ Employed in laboratory
- ☐ ☐ ☐ ☐ Contact with recent foreign arrival
☐ Casual ☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____
Specify country: _____
- ☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ Patient could not be interviewed☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk**PATIENT PROPHYLAXIS/TREATMENT****PUBLIC HEALTH ISSUES**

Y N DK NA

- ☐ ☐ ☐ ☐ Employed as food worker
- ☐ ☐ ☐ ☐ Non-occupational food handling (e.g. potlucks, receptions) during contagious period
- ☐ ☐ ☐ ☐ Employed in child care or preschool
- ☐ ☐ ☐ ☐ Attends child care or preschool
- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ____/____/____
Agency and location: _____
Type of donation: _____
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Exclude individuals from sensitive occupation (HCW, child care) or situation (child care) until 3 negative stools
- ☐ Consider excluding symptomatic contacts from sensitive occupations (HCW, food, child care) or situations (child care) until 2 negative stools
- ☐ Notify others sharing exposure
- ☐ Hygiene education provided
- ☐ Child care inspection
- ☐ Follow-up of household members
- ☐ Work or child care restriction for household member
- ☐ Notify blood or tissue bank
- ☐ Other, specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ____/____/____

Local health jurisdiction _____

Record complete date ____/____/____